State of Iowa
Department of Education
IOWA VOCATIONAL REHABILITATION SERVICES

RE: _____
NAME *(Typed or Printed)*

_____
DATE OF BIRTH *and/or* **SS#/OTHER IDENTIFIER**

AUTHORITY FOR RELEASE OF INFORMATION

To:	I, the undersigned, hereby authorize you to disclose and deliver to:

THE FOLLOWING SPECIFIC INFORMATION: APPROXIMATE DATE(S) OF REPORT(S):

- ☐ Medical: Evaluation and Treatment Reports
- ☐ Hospital: Admitting History/Exam, Consultant Exam and Discharge Summary
- ☐ Psychiatric: Clinical Notes and Discharge Summary Letters
- ☐ Psychological: Evaluation and Treatment Reports
- ☐ Transcript of Grades and other Performance Reports
- ☐ Other _____

I understand that the information you release will be used as appropriate and necessary in the determination of eligibility for, and the development of a program of rehabilitation services; or

- ☐ Other _____

I understand that the information may be given verbally or in written form and this release includes permission to furnish IVRS copies. This form will be kept in my VR casefile and I understand that I may review the disclosed information by contacting the person, agency, or entity releasing the information. I understand that the information will be used for purposes relating to my rehabilitation programming, and will not be released to any other person, agency, or entity for any purpose without my written permission except as required by Federal or State Law. Disclosure of this information carries with it the potential for unauthorized redisclosure and once information is disclosed it may no longer be protected by federal privacy regulations. I understand that any action on my part to deny access to information that is essential to my rehabilitation programming may result in delaying or stopping rehabilitation services. I also understand that I may withdraw this permission at any time by sending written notice to Iowa Vocational Rehabilitation Services, 510 East 12th Street, Des Moines, Iowa 50319. If I withdraw my permission, I understand that the withdrawal does not apply to information already received by IVRS prior to my written withdrawal. In the absence of any withdrawal or special instructions below, **this release will automatically expire 12 months from the date of my signature.**

Restrictions and/or Comments: _____

SPECIFIC AUTHORIZATION FOR RELEASE OF INFORMATION
PROTECTED BY STATE OR FEDERAL LAW:
If information of the following types is available I give permission for its release:
(Client must check appropriate box[es])

	YES	NO
1. SUBSTANCE ABUSE	☐	☐
2. MENTAL HEALTH	☐	☐
3. HIV-RELATED INFORMATION	☐	☐

_____
SIGNATURE OF CLIENT *DATE*

_____
SIGNATURE OF LEGAL GUARDIAN *DATE*

In order for the above information to be released, you must sign here AND to the right.

_____ _____
CLIENT SIGNATURE DATE SIGNED

_____
STREET/P.O. BOX

_____
CITY/STATE/ZIP

_____
PARENT/GUARDIAN IF CLIENT IS A MINOR/WARD

_____
SIGNATURE OF WITNESS

For Responding Agency Use Only:
_____Staff Initial _____Date Released _____Date Copy Sent to Client